

ATHLETIC PRE-PARTICIPATION SCREENING EXAM
Developed by the SCCMA Sports Medicine Committee

PART 1: Identifying Data (to be completed by student and parents or guardian)

Name (last name first) _____ School _____ Grade _____

Address: _____

City: _____ Zip Code _____ Home Phone () _____

Age: _____ Sex: M ☐ F ☐ Sport(s) _____ Birth Date: _____

Doctor's Name: _____ Doctor's Phone: (____) _____

Doctor's Address: _____

Health Insurance Carrier: _____

HEALTH HISTORY (Must be completed prior to the examination)

YES	NO	Has this student had any:	YES	NO	Is there any history of:
		1 Chronic or recurrent illness?			16 Injuries requiring physician treatment?
		2 Illness lasting over 1 week?			17 Neck or back injury?
		3 Hospitalization?			18 Knee injury?
		4 Surgery other than removal of tonsils?			19 Shoulder or elbow injury?
		5 Missing organs (eye, kidney, testicle)?			20 Ankle injury?
		6 Allergies (medicines, insect bites, food)?			21 Other serious joint injury?
		7 Problems with heart or blood pressure?			22 Broken bones (fractures)?
		8 Chest pain or severe shortness of breath with exercise?			
		9 Dizziness or fainting with exercise?			FURTHER HISTORY
		10 Fainting, bad headaches or convulsions?			Is there any reason why this student should not participate in sports?
		11 Concussion or loss of consciousness?			
		12 Heat exhaustion, heatstroke, or other problems with heat?			Has any family member died suddenly at less than 40 years of age of causes other than an accident?
					Has any family member had a heart attack at less than 55 years of age?

YES	NO	Does this student:
		13 Wear eye glasses or contact lenses?
		14 Wear dental bridges, braces, or plates?
		15 Take any medications? Please list them: _____

Date of last known tetanus (lockjaw) shot: _____

Use this space to explain any yes answers to the above questions

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PART 2: General Examination (to be completed by the examining physician)

	Normal	Abnormal (Describe)	Pulse: _____
Eyes, Ears, Nose, Throat			Blood Pressure: _____
Skin			Height: _____
Lungs			Weight: _____
Heart			Visual Acuity: _____
Abdomen			R _____
Genitalia/hernia (males)			L _____

Suggested Musculoskeletal Exam

		NL	AB			NL	AB	Describe Abnormals
	MOTION/STRENGTH			K	KNEE JOINT			
N	Flexion			N	Effusion			
E	Extension			E	Tenderness			
C	Rotation left			E	QUADRICEPS			
K	Rotation right				Size			
	Lateral flexion right			&	& Defects			
	Lateral flexion left				PATELLA			
				S	Tenderness			
	MOTION/STRENGTH			U	Crepitus			
S	Forward flexion			R	Abnormal tracking			
H	Abduction			R	Subluxable			
O	Extension			O	PATELLAR TENDON			
U	Internal rotation			U	TIBIAL TUBERCLE			
L	External rotation			N	LIGAMENTS			
D	Horizontal Adduction			D	Medial collateral			
E	STABILITY			I	Lateral collateral			
R	A-C JOINT			N	Anterior cruciate			
				G	Posterior cruciate			
	MOTION/STRENGTH				CARTILAGE TESTING			
E	Biceps extension			A				
L	Triceps extension			R	STRENGTH			
B	Supination			E	Hip flexors			
O	Pronation			A	Hamstrings			
W				S				
	GENERAL FLEXIBILITY				MOTION/STRENGTH			
	Hamstrings				Plantarflexion			
	Lumbar Spine				Dorsiflexion			
	Adductors (groin)				Inversion			
	Achilles				Eversion			
	Quadriceps				LIGAMENTS			
	WRIST/HAND				SPINE/SCOLIOSIS			
					FEET			

RECOMMENDATIONS:

- ☐ Unlimited Participation
☐ Clearance withheld pending further evaluation (comment below)
☐ Participation limited to specific sports (comment below)
☐ No athletic participation (comment below)

COMMENTS:

Signature: _____ MD/DO Date: _____